DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445460	A. BUILDING _____ B. WING _____	08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCO MANOR NURSING AND REHABILITATION CENTER, INC	813 S DICKERSON RD GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual Recertification Survey conducted on 8/3/15 - 8/5/15, at Vanco Manor Nursing and Rehabilitation, complaint #36593 was investigated. and no deficiencies were cited in relation to the complaint under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	F225 Plan of Correction (POC) 1. What corrective actions well be accomplished for those residents found to have been affected by the deficient practice. a. On8/5/15, an interview was conducted with resident #58 by Social Services, the resident expressed that she was happy and content with the care she receives.	8/5/15
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	b. On 8/5/15, resident #58 was addressed by the staffing coordinator (LPN), the injury was assessed and the case had resolved with no current issues present. c. A referral was made by social services for resident #58 to be seen by the psych nurse practitioner on 9/1/15to assess the psychosocial effect with interventions as suggested/as needed. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. a. On 8/26/15 all alert and orientated residents were interviewed by the DON, ADON, and Social Services to determine if there are any current safety concerns and also informed them on the process and avenues on how to report any concerns as well as the types of abuse. No additional concerns were noted through the course of this process. 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur. a. On 8/27/15, all staff was in-serviced by the DON, ADON, and Staff development coordinator on abuse, occurrence investigation policies, and reporting procedure.	8/5/15 9/1/15 8/26/15 8/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] Administrator 8/28/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, interview and Nurse Event Note review the facility failed to complete a thorough occurrence investigation for 1 (Resident #58) of 29 residents reviewed . The findings included: Review of a facility policy titled Occurrence Investigations dated 9/14 revealed "...After an occurrence has happened it is important to get accurate information in a thorough investigation that will help uncover the cause of the occurrence...for the prevention of future occurrences...an injury (including bruises, abrasions and skin tears etc.) that was not observed by any person...is considered an injury of unknown origin and requires a thorough investigation..." Medical record review revealed Resident #58 was admitted to the facility on 7/30/08 with diagnoses including Atrial Fibrillation, Spinal Stenosis, Disc Displacement, Anxiety and Diabetes. Medical record review of a Quarterly Minimum Data Set dated 5/15/15 revealed Resident #58 was cognitively intact and used a wheelchair for	F 225	b. On 8/5/15, the formal occurrence investigation policy was added to the orientation packet for all nurses and Certified Nursing Assistants by the Staff Development Coordinator. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e, what assurance program will be put in place. a. The Administrator or designee will monitor for compliance by conducting random resident interviews daily x30 days, then weekly x4 weeks, an monitored on going and as needed. Investigations will be monitored daily as needed by the administrator or designee. The results will be discussed during the monthly patient care and services meeting and quarterly during the QA committee which consists of the Medical Director, Administrator, DON, ADON, Social Services, Dietary Manager, Staff Development Coordinator, and Activates Director. b. Completion date: September 15th, 2015.	8/5/15 9/15/15

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F 225	Continued From page 2 mobility. Observation and interview of Resident #58 on 8/3/15 at 11:10 AM in the resident's room revealed when the resident was asked if she had ever been abused by anyone stated, "Yes, another resident hit me with her cane about 4 or 5 months ago." When asked if there was any injury the resident stated, "Yes, I had a knot on my leg (pointed to left shin area)." The resident's legs were observed to be edematous and moderately reddened. Continued interview revealed when the resident was asked if she had notified staff of the incident stated, "Yep, I told everybody. Everybody knew about it and the lady that hit me was sent out the next day." The resident was unable to recall the name of the resident that struck her with the cane. Interview with the Administrator in the Administrator's office on 8/5/15 at 8:35 AM when asked for all facility investigations regarding Abuse/Injury of Unknown Origin, the Administrator was unable to provide an investigation regarding Resident #58. Continued interview with the Administrator and the DON in the hallway outside of the Administrator's office when asked about an investigation regarding a resident that was hit on the leg with a cane by another resident, neither the Administrator nor the DON could recall such an incident. Review of a Nurse Event Note dated 3/9/15 at 4:12 PM documented the type of occurrence was unobserved and marked "other"; the location was room 207 A; the following detailed description of the occurrence was documented as "Resident has increased agitation noted, wandering in and out of rooms waving cane around. Resident	F 225		

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F 225	Continued From page 3 redirected easily, NP [Nurse Practitioner] made aware of increased agitation, order to send to [named hospital] for increased agitation." The interventions implemented to prevent reoccurrence documented, "Kept in view of nursing until transferred to ER [Emergency Room]." The note was signed by LPN #1. Review of a Nurse's Event Note dated 3/9/15 at 4:20 PM documented the type of occurrence was unobserved; the location was room 214 B; an injury of a bruise was noted and the following detailed description of the occurrence was documented as "Resident [#58] stated resident from room 207 B had came in to room and she was asking her to leave and she was hit by cane. Left leg had small bruise area, legs are swollen as normal [with] discoloration to them." The immediate steps implemented to prevent recurrence documented " Resident B removed from room. Resident A [Resident #58] stated she was OK just wanted her out of room." The note was signed by LPN #1. Medical record review revealed there were no clinical nursing notes documented for the resident between 3/4/15 and 3/24/15. Interview with LPN #1 on 8/5/15 at 1:32 PM in the dining room confirmed she had completed the event notes for both residents on 3/9/15. When the LPN was asked if she considered this abuse, she stated, "No, it was an accident and it was not intentional. [named resident] had severe short term memory loss and could not remember where her room was, would become tearful, agitated, and swing her cane around while wandering in and out of other resident's rooms." Continued interview revealed the LPN heard and	F 225		

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F 225	Continued From page 4 saw the resident's behavior and went to help redirect her and calm her down. Continued interview revealed she spoke with Resident #58 after the resident voiced she had been struck in the leg by the residents cane. The LPN confirmed she assessed the resident's left leg and the resident said she was OK, she just wanted that resident to stay out of her room. Continued interview confirmed the resident that struck Resident #58 with her cane and had been sent to the ER, had been admitted to a Geri-Psych facility, and had not returned to this facility. Interview with LPN #2 on 8/5/15 at 1:45 PM in the dining room when asked if she remembered anything regarding an incident with Resident #58 being struck with a cane by another resident stated, "Yes, [named resident] was admitted with anxiety, agitation and severe short term memory loss." The LPN confirmed she had assessed the left leg of Resident #58 and no injury was noted. Continued interview revealed the LPN stated Resident #58 did not complain of any pain, she just complained that she was hit on the leg by the cane. Continued interview confirmed Resident #58's son was aware of the incident and that once he learned the resident was no longer in the facility, he "had no problem with it." Continued interview confirmed LPN #2 did not view the incident as abuse, but as an unfortunate accident due to the unintentional behaviors of another resident, and was not investigated as such. Interview with the DON on 8/5/15 at 2:07 PM in the conference room confirmed she had never been notified Resident #58 had been struck on the leg with a cane by another resident. Continued interview confirmed the DON should have been notified of the incident. Continued	F 225		

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F 225	Continued From page 5 interview confirmed an investigation should have been completed per facility policy regarding this incident as it was not observed and there was an injury of unknown origin. Continued interview with the DON stated the incident should have been reviewed in the daily clinical meeting and priority charting should have been completed for 72 hours. The DON confirmed the facility failed to complete a thorough investigation for the resident.	F 225		